Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: VONO PO BOX 15640 FORT WORTH TX 76119	MFDR Tracking #: M4-04-3988-01
	DWC Claim #:
	Injured Employee:
Respondent Name and Box #: OLD REPUBLIC INSURANCE CO Box #: 42	Date of Injury:
	Employer Name:
	Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "We have submitted a claim to the Carrier for date of service 01-09-03 for a walking cane." "Total dollar amount in dispute is **$50.00.**" "The disputed issue is that the Carrier's original explanation of benefits we received, denied the claim stating 'DUPQ DUPL = these services have already been considered for reimbursement' and no payment was made. We resubmitted the claim for reconsideration as this is not a duplicate charge. We then received another explanation of benefits stating the same." "The expected out come of this issue is that we feel the claim should be paid. This is not a duplicate charge and we have not received any other explanation of benefits for this claim."

Principal Documentation:

1. DWC 60 Package
2. Medical Bill(s)
3. EOB(s)
4. Medical Records
5. Total Amount Sought per Table of Disputed Services- $26.70

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: "Error made & we will pay the 26.70 as fee schedule"

Principal Documentation:

1. Response Package

PART IV: SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Calculations	Amount in Dispute	Amount Due
1/9/2003	E0100 (D0600)	Per 1991 MFG the MAR for D0600 is $26.70	$26.70	$26.70
			Total Due:	$26.70

PART V: FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Tex. Lab. Code Ann. §413.031 of the Texas Workers' Compensation Act, and pursuant to all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. This request for medical fee dispute resolution was received by the Division on November 26, 2003. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on December 4, 2003 to send additional documentation relevant to the fee dispute as set forth in the rule.

2. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under*

the Texas Workers' Compensation Act, effective April 1, 1996, sets out the reimbursement for medical treatment.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated 8/6/2003

   - DUPQ DUPL – These services have already been considered for reimbursement.

   Explanation of benefits dated 9/1/2003

   - DUPQ DUPL – These services have already been considered for reimbursement.

Issues

1. What is the applicable rule for reimbursement?
2. Is the requestor entitled to additional reimbursement?

Findings

1. Division rule at 28 TAC §134.201, titled *Medical Fee Guideline for Medical Treatments and Services Provided Under the Texas Workers' Compensation Act*, effective April 1, 1996, DURABLE MEDICAL EQUIPMENT (DME) GROUND RULE IX. C, titled Billing, states that "The provider shall use the HCFA-1500 Form for billing. Invoices should be billed at the provider's usual and customary rate. Reimbursement shall be an amount pre-negotiated between the provider and carrier of there is no pre-negotiated amount, the fair and reasonable rate. A fair and reasonable reimbursement shall be the same as the fees set for the 'D' codes in the 1991 Medical Fee Guideline."

   Review of the documentation submitted by the parties to this dispute finds no documentation to support that an amount was pre-negotiated between the provider and carrier for the disputed HCPCS codes; therefore, the insurance carrier shall reimburse the provider the fair and reasonable rate for the item described per Division rule at 28 TAC §134.201 DME GROUND RULE IX.

2. HCPCS code E0100 is described as "Cane, includes canes of all materials, adjustable or fixed, with tip." Division rule at 28 TAC §134.201, DME GROUND RULE IX, C, titled Billing states fair and reasonable rate will be the fees set in the 1991 MFG. This HCPCS code is comparable to MFG 1991 D code "D0600-Cane, aluminum." Per the 1991 MFG, D code D0600 has a purchase price of $26.70. The insurance carrier paid $0.00. The requestor is entitled to the difference between $26.70 and amount paid of $0.00 = $26.70.

Conclusion

The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation supports the reimbursement amount sought by the requestor. For the reasons stated above, the division finds that the requestor has established that reimbursement is due. As a result, the amount ordered is $26.70.

PART VI: ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031 and §413.019 (if applicable), the Division has determined that the requestor is entitled to $26.70 reimbursement for the services involved in this dispute. The Division hereby **ORDERS** the respondent to remit to the requestor the amount of $26.70 plus applicable accrued interest per Division rule at 28 Tex. Admin. Code §134.803, due within 30 days of receipt of this Order.

Authorized Signature	Medical Fee Dispute Resolution Officer	**June 4, 2010** Date

PART VII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 Tex. Admin. Code §148.3(c).

Under Texas Labor Code § 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.